STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155670		A. BUII	LDING	00	COMPL		
		155670	B. WIN			09/29/2	011
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
KINDDE	O TO ANOITION AL C	ARE AND RELIAD ANGEL DIVE		I	OSEBUD LANE		
KINDREL) TRANSITIONAL C	CARE AND REHAB-ANGEL RIVER		NEWBU	JRGH, IN47630		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
F0000							
	This visit was for	r a recertification and	EU	000			
		rvey. This visit included	10	000			
		-					
	_	of complaint number					
	IN00096312.						
	Cameral Line 1						
	Complaint numb						
		estantiated, Federal/State					
		ed to the allegations are					
	cited at F323.						
	-	eptember 21, 22, 23, 26,					
	27, 28, 29, 2011						
	Facility number:						
	Provider number						
	AIM number: 20	00258520					
	Survey team:						
	Diane Hancock,	RN TC					
	Amy Wininger, F	RN					
	Census bed type:						
	SNF/NF	110					
	Total	110					
	Census payor typ	oe:					
	Medicare	23					
	Medicaid	58					
	Other	29					
	Total	110					
	Sample: 22						
	Sample. 22						
LABORATOR	Y DIRECTOR'S OR PROV	TIDER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE		TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

MQ3411

Facility ID:

011049

If continuation sheet

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155670		(X2) MI A. BUII		NSTRUCTION 00	(X3) DATE (COMPL 09/29/2	ETED	
	PROVIDER OR SUPPLIER D TRANSITIONAL O	CARE AND REHAB-ANGEL RIVER	B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE OSEBUD LANE JRGH, IN47630	09/29/2	011
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0282 SS=E	These deficiencies findings cited in 16.2. Quality review con Cathy Emswiller The services proving facility must be proving accordance with plan of care. Based on observative record review, the residents with considerate with a Peripheral Catheter [Picc] lichanged as order resident receiving significant medical Resident #31 and splints ordered, by residents sampled #43 had a Picc linding ordered weekly a for 1 of 2 resident dressing change, insulin ordered argiven for 26 days	es also reflect state accordance with 410 IAC ompleted 10/3/11	F0	282	F282 AngelRiverHealth and Rehabilitation Plan of Correction Annual/Complaint Survey Date: September 21 2011 IndianaStateDept of Health Tag F 282 Corrective action implemented for those residents found to have been affected For resident's #'s 31 ar 48 care plans and Certified Nursing	- <u>e</u>	10/24/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:			ULTIPLE CO	NSTRUCTION 00	(X3) DATE S	ETED	
		155670	B. WIN	IG		09/29/20)11
NAME OF	PROVIDER OR SUPPLIEI	· · · · · · · · · · · · · · · · · · ·		1	ADDRESS, CITY, STATE, ZIP CODE		
KINDDE	D TO ANOITION AL				OSEBUD LANE		
		CARE AND REHAB-ANGEL RIVE	:K	NEWBU	JRGH, IN47630		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	` `	NCY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION DATE
IAG	sample of 22.	LESC IDENTIFTING INFORMATION)		IAG	Assistant (CNA) work		DAIL
	sample of 22.				sheets were reviewed	and	
	Findings include	<u>.</u>			residents assessed for		
	i manigs merado	··			appropriateness and	'	
	1 A The clinic	al record of Resident #31			accuracy of splint usage	ne	
		n 09/27/11 at 3:40 P.M.			and splints applied		
		rated diagnoses included,			accordingly		
		ited to, dementia and			For resident # 43, the o	care	
		ge disorder. The record			plan and Treatment		
	1	Resident #31 was			Record were reviewed		
	receiving Hospi	ce services.			and corrected to reflec	t	
					current physician orde	ers	
	Resident #31 wa	as identified, on 09/21/11			for PICC line dressing		
	11:35 A.M., dur	ing the initial tour by UM			and dressing changed		
	[Unit Manager]	#1 as not interviewable			accordingly		
	and "having pro	blems with her hands".			For resident # 14 the		
	Resident #31 wa	s observed, at that time,			Medicine Administration	on	
	to be lying in be	d with two carrot splints			Record (MAR) was		
	lying at her side	, her bilateral hands were			corrected on 8/30/2011	to	
	observed to be c	ontracted.			reflect accuracy and		
					appropriateness of		
	Resident #31 wa	s observed, on 09/27/11			Insulin Dosage and		
	· ·	p in a wheelchair with no			Administration		
	carrot splints in	her hands.					
					Other residents having	1	
		s observed, on 09/27/11			the potential to be		
	· ·	ting in a geri-chair in the			affected by the same		
	1	h no carrot splints in her			<u>practice</u>		
	hands.				- All maaidanta laasi		
	TEI A	ını '' ın			All residents havi	· 1	
	1	l Physician's Recaps			splints, PICC lines and Insulin orders have the		
		s not limited to, orders				=	
	1	Il times to hands except			potential for being		
	for hand cleanin	g.''			affected by this praction	ce	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPLETED
		155670	B. WIN			09/29/2011
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER	L			OSEBUD LANE	
KINDRFI	D TRANSITIONAL (CARE AND REHAB-ANGEL RIVE	-R		JRGH, IN47630	
						1 275
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
TAG	` ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
1710	REGULATORI OR	ESC IDENTIFICATION OR MATION	-	1710		
	A Come Diam Come				and will be identified b	
		contractures, dated			Medical Record Repor	I
	· · · · · · · · · · · · · · · · · · ·	ed an addendum of			For these residen	ts,
		hand splintsapproach:			the Physician Orders,	
	change to carrots	S."			Certified Nursing	
					Assistant worksheets,	
	The most current	t MDS [Minimum Data			MAR's, Treatment	
	Set Assessment],	, dated 08/16/11,			Administration Record	ls
	indicated Reside	nt #31 had impairment to			(TAR) and Care Plans	
	bilateral upper ex	xtremities.			were reviewed for	
					accuracy	
	The undated CN.	A [Certified Nursing				
		ment sheets Assignment			Measures put into plac	ce
	1 2	the DoN [Director of			and systemic changes	
	' *	21/11 at 2:00 P.M.,			made	-
	""	dent #31 was to have			<u>made</u>	
	ĺ				In - service education	for
	"therapy carrots	at all times.				
					nursing staff regarding	9
		vith UM #1, on 09/28/11			use of Care Plans, the	
	· ·	indicated Resident #31			necessity of following	I
	was to wear the o	carrots at all times, but "a			care plan for residents	I
	lot of times she t	hrows them."			who are utilizing splin	its,
					have PICC lines and	
	B. The clinical r	ecord of Resident #48			receive insulin	
	was reviewed on	09/28/11 at 9:15 A.M.			In - service education	
	The record indicate	ated the resident was a			presented regarding th	ne
		and the diagnoses			transcription of physic	I
	included, but wa	-			orders was presented	I
	Parkinson's.	,			all licensed nursing st	I
	i dikilisoli s.					
	Pacident #18 wa	s identified by RN #1,				
					Corrective actions will	he
	"	r on 09/21/11 at 11:35				
	· · · · · · · · · · · · · · · · · · ·	rviewable and having			monitored to ensure th	
	contractures of the	ne bilateral hands.			practice does not recu	<u> r</u>

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPLE	TED
		155670	B. WIN			09/29/20	11
		1	B. WII.		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEI	R			OSEBUD LANE		
KINDRE	D TRANSITIONAL (CARE AND REHAB-ANGEL RIVE	R	1	JRGH, IN47630		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG	+	R LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	-	DATE
		as observed at that time to			<u>by:</u>		
	be lying in bed v	with bilateral upper			_		
	extremity contra	ctures with no splints.			The DNS, ADNS or		
	Upon query, at t	hat time, RN #1 indicated			designee will complete	•	
	Resident #48 wa	s holding gauze in her			random checks of		
	contractures.				physician orders to		
					assure accuracy in		
	The August 201	1 Physician's Recap			transcription of physic	ian	
	1	is not limited to, an order			orders five (5) times pe		
		wear therapy carrots at all			week times two (2)		
	times"	wear therapy current at an			months and then two (2)	
					times per week times f	· I	
	The most curren	t MDS [Minimum Data			(4) months		
		, dated 07/13/11,			The DNS, ADNS or		
	1	ent #48 had bilateral					
					designee will complete	†	
	impairment of tr	ne upper extremities.			random checks of the		
					Care Plan and the CNA	١	
		as observed on 09/27/11 at			work sheets to assure		
	1	in bed with bilateral			accuracy two (2) times		
		contractures, gauze was			per week times six (6)		
	observed in her	hands.			months		
					The DNS, ADNS or		
	Resident #48 wa	as observed on 09/28/11 at			designee will complete	•	
	9:40 A.M., lying	g in bed with bilateral			random checks of		
	upper extremity	contractures, gauze was			Physician orders and		
	observed in her	hands.			Treatment Administrati	on	
					Records to assure PIC	c	
	The undated CN	A assignments sheets			line dressings are		
		provided by the DoN on			changed and documen	ted	
	1 -	P.M., indicated, "extra			accurately five (5) time		
	infothere [ther				per week times two		
		5there [therapy] carrot			months and then two		
	Δ Care Plan da	ted 08/05/10, indicated a			times per week times f	our	
	•	ntractures bilateral hands"			(4) months		
	problem of cor	mactures offateral nands			(+) 1110111113		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155670		A. BUII	LDING	00	COMPL 09/29/2	ETED
NAME OF PROVIDER OR SUPPLIED KINDRED TRANSITIONAL			STREET A	DDRESS, CITY, STATE, ZIP CODE DSEBUD LANE RGH, IN47630	1	
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES SCY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	πE	(X5) COMPLETION DATE
with intervention were not limited hands," In an interview were to have the carrotall times, except In an interview we shall times, except In an interview we shall times, except In an interview we shall times washed Residen "[Resident #48] carrot in her right her left." RN #1 open a drawer and stuffed carrot. It to look throughed smaller carrot are "I don't know with must have throw indicated, "There now while her hand of Removable Performed by the A.M., indicated, splint according In an interview we op/28/11 at 11:0	as the triangle of the second			Findings will be monitored monthly by Performance Improvement Committe times six (6) months Completion Date October 24, 2011	the	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155670		<u> </u>	IULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPI 09/29/2	LETED	
		193070	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	09/29/2	.011
NAME OF F	PROVIDER OR SUPPLIER			1	OSEBUD LANE		
KINDREI	D TRANSITIONAL C	CARE AND REHAB-ANGEL RIVE	ĒR	NEWBL	JRGH, IN47630		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF			(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
	her hands at all to						2000
	contractures."	•					
	was reviewed on	ecord of Resident #43 09/22/11 at 10:15 A.M. ated, the diagnoses,					
		re not limited to, DVT					
		mbosis] {blood clot} and					
	malnutrition.						
	Resident #43 was identified, during initial tour on 09/21/11 at 12:15 P.M., by UM #1 indicated Resident #43 was interviewable.						
	A Physician teler	phone order, dated					
		e, included an order for					
	"1. Picc [an intra	avenous catheter]- Flush					
	10 cc NS every s weekly-Picc."	hift 2. change dressing					
		he Picc included, but was proaches, "change					
		s observed on 09/22/11 at in the chapel. A Picc					
	ľ	s observed to be intact on					
	the right arm and	l dated 09/11/11.					
	at 9:45 A.M., sitt	s observed, on 09/23/11 cing in her room. A Picc s observed to be intact on					
	the right arm date	ed 09/11/11.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155670		(X2) MU A. BUILI B. WING	DING	00	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIEF	CARE AND REHAB-ANGEL RIVE	≣R	5233 RC	DDRESS, CITY, STATE, ZIP CODE DSEBUD LANE RGH, IN47630		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	In an interview v Nursing], on 09/ indicated, Reside line dressing cha transposed from had not been don The policy and p Change for Vasc provided by the A.M. indicated, local and system IV [intravenous] Transparent men changed every 7 needed].	with the DoN [Director of 23/11 at 10:55, she ent #43 order for a Picc ange weekly had not been the admission orders and he as ordered. Procedure for Dressing ular Access Devices DoN on 09/29/11 at 9:00 Purpose To prevent ic infection related to the site. Policy2. Inbrane dressings are days and PRN [as					
	_	Physician's Order Recap s not limited to, and order					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPL		
		155670	A. BUI B. WIN	LDING		09/29/2	
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			5233 R	OSEBUD LANE		
KINDREI	D TRANSITIONAL C	CARE AND REHAB-ANGEL RIVE	R	NEWBL	JRGH, IN47630		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710	for :	ESC IDENTIFY THAT IN ORAM THOM	+	mo	·		DATE
		g scale coverage QID					
] -before meals and at hs					
	[hour of sleep]:	j ottore memo miu we no					
	< [less than] 70=	No coverage					
	70-150=2 units						
	201-250=4 units						
	251-300=6 units						
	301-350=8 units						
	351-400=10 unit	S					
	> [greater than] 4	400=10 units and call MD					
	[physician]						
	Use half dose at l	hs"					
	The August 2011	Physician's Order Recap					
	page 4 included a	a handwritten note signed					
	by the physician	dated 08/04/11 which					
	indicated, "Start	Lantus 10 units at hs"					
	The August 2011	Medication					
	-	Record [MAR] lacked any					
		nat Lantus 10 units was to					
	be given at bedti	me.					
		onitoring Flow Sheets for					
	_	icated Resident #14					
	•	ated blood sugars on the					
	_	and received insulin per					
	the ordered slidir	_					
	08/06/11 at 8:00 08/13/11 at 5:00						
	08/13/11 at 7:00 08/20/11 at 4:00	•					
	08/20/11 at 4:00 08/27/11 at 8:00						
	00/2//11 at 0.00	1 .1 v1.—+ U/					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	
		155670	B. WIN			09/29/20	011
NAME OF I	DROVIDED OD GUDDI IED		!	STREET A	ADDRESS, CITY, STATE, ZIP CODE	!	
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>		5233 R	OSEBUD LANE		
		CARE AND REHAB-ANGEL RIVI	ER		JRGH, IN47630		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· `	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
IAG			<u> </u>	IAU	Directive (DATE
	1 -	lephone Order dated					
	1	e, indicated, "give 15 u					
	1 * *	og now-recheck blood					
	1 ~	Notify MD if blood sugar					
	>300."						
	A Physician's Tel	lephone Order dated					
		P.M. indicated, "Recheck					
		in 2 hoursGive total of					
	15 u Novolog no						
	A Physician's Tel	lephone Order dated					
	1 -	P.M. indicated, "Give 20					
	u Novolog now	•					
	A Physician's Tel	lephone Order dated					
		P.M. indicated, "Give 12					
		recheck in 2 hours-if over					
	400 notify MD a						
	A Unit 100 Fay o	lated 08/30/11 indicated,					
		w order] 08/04/11 Lantus					
	I -	ic] resident did not					
	-	ication all mo [month]"					
	10001ve tills illedi	eation an mo [month]					
	A Medication Va	riance Report Worksheet					
	provided by the l	DoN [Director of					
	Nursing] on 09/2	23/11 at 10:55 A.M.					
	indicated, "Lantu	ıs 10 unitsNo					
	medication giver	Adverse Drug					
	Reaction: YesT	Type of Effects observed					
		er" with a handwritten					
	note that indicate	ed, "increased blood sugar					
	resulting in incre	ased coverageType of					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155670		A. BUI	LDING	NSTRUCTION 00	(X3) DATE : COMPL 09/29/2	ETED	
NAME OF F	PROVIDER OR SUPPLIER		B. WIN		ADDRESS, CITY, STATE, ZIP CODE	03/23/2	011
		CARE AND REHAB-ANGEL RIVE	:R		OSEBUD LANE JRGH, IN47630		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
	note that indicate error-order rec'd transcribed Me RatingError; H error occurred that to or resulted in tresident and required handwritten nota of the worksheet physician] wrote and not on T.O. [on 3rd page instead of the worksheet physician] wrote and not on T.O. [on 3rd page instead of the worksheet physician] wrote and not on T.O. [on 3rd page instead of the worksheet physician] wrote and not on T.O. [on 3rd page instead of the worksheet physician] wrote and not on T.O. [on 3rd page instead of the worksheet physician] wrote and not on T.O. [on 3rd page instead of the worksheet physician] wrote and not on T.O. [on 3rd page instead of the worksheet physician] wrote and not on T.O. [on 3rd page instead of the worksheet physician] wrote and not on T.O. [on 3rd page instead of the worksheet physician] wrote and not on T.O. [on 3rd page instead of the worksheet physician] wrote and not on T.O. [on 3rd page instead of the worksheet physician] wrote and not on T.O. [on 3rd page instead of the worksheet physician] wrote and not on T.O. [on 3rd page instead of the worksheet physician] wrote and not on T.O. [on 3rd page instead of the worksheet physician] wrote and not on T.O. [on 3rd page instead of the worksheet physician] wrote and not on T.O. [on 3rd page instead of the worksheet physician] wrote and not on T.O. [on 3rd page instead of the worksheet physician] wrote and not on T.O. [on 3rd page instead of the worksheet physician] wrote and not on T.O. [on 3rd page instead of the worksheet physician] wrote and not on T.O. [on 3rd page instead of the worksheet physician] wrote and not on T.O. [on 3rd page instead of the worksheet physician] wrote and not on T.O. [on 3rd page instead of the worksheet physician] wrote and not on T.O. [on 3rd page instead of the worksheet physician] wrote and not on T.O. [on 3rd page instead of the worksheet physician] wrote and not on T.O. [on 3rd page instead of the worksheet physician] wrote and not on T.O. [on 3rd page instead of the worksheet physician] wrote and not on T.O.	d 04/20/11 for Type II d approaches which					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155670		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE (COMPL 09/29/2	ETED	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-ANGEL RIVE			₹	5233 R	ADDRESS, CITY, STATE, ZIP CODE OSEBUD LANE JRGH, IN47630		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0309 SS=D	must provide the material to attain or maintain physical, mental, as in accordance with assessment and passed on observative record review, the aresident with a Central Catheter dressing changed 43), in that Resid dressing changed was not performed sampled for IV data facility sample of Findings included The clinical recording reviewed on 09/2 recording included the clinical recording facility were not limited to the clinical recording for IV data facility sample of the clinical recording facility sample of the clini	ation, interview, and e facility failed to ensure Peripherally Inserted [Picc] line had the las ordered (Resident lent #43 had a Picc line ordered weekly and it ed for 1 of 2 residents ressing changes in a f 22. ard of Resident #43 was f2/11 at 10:15 A.M. The the diagnoses, included, ted to, DVT [Deep Vein	F0	309	F 329 Angel River Health an Administration Plan of Correction Annual/Complai Survey Date: September 2 2011 Indiana State Dept of Health Tag F 329 Corrective Action Taken for those residents found to have been affected. For resident 20, 68 and 89 the following actions were take immediately. Nursing and social services staff assessed each for necessity of medication, behaviors and potential for behaviors. Pharmacy consultant and resident's physician consulting regarding necessity and appropriateness of medicate Social Service staff implemented behavior monitoring logs were present on resident 68 and resident Care Plans were updated to reflect specific non pharmaceutical intervention Nursing staff instructed to document specific non pharmaceutical intervention	nt 1, en he n s ited	10/24/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLET	TED
		155670	B. WIN			09/29/201	11
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			OSEBUD LANE		
KINIDDE	D TDANSITIONAL (CARE AND REHAB-ANGEL RIVER)		JRGH, IN47630		
			<u> </u>	l .	J. C. I., II. 47 000		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	re (COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	·		DATE
	10 cc NS every s	shift 2. change dressing			attempted to avert behavior	'	
	weekly-Picc."				before administering		
					medication		
	A Care plan for the Picc included, but was				Identify other residents have		
	not limited to, approaches, "change				the potential to be affected the same practice and	Dy	
					corrective actions taken		
	dressing weekly				All residents receiving psyc	ho	
		s observed on 09/22/11 at			active medications are		
		g in the chapel. A Picc			identified by Medical Recor	d	
	line dressing wa	s observed to be intact on			Reports Chart reviews will		
	the right arm and	d dated 09/11/11.			completed for all residents		
					receiving psycho active		
	Resident #43 wa	s observed, on 09/23/11			medications for: appropriat	e	
		ting in her room. A Picc			diagnosis, non-pharmaceut	ical	
		_			interventions, and monthly		
	1	s observed to be intact on			behavior monitoring flow s	heet	
	the right arm dat	ed 09/11/11.			Measures put into place an	d	
					systemic changes to ensur		
	In an interview v	with the DoN [Director of			the practice does not recur		
	Nursing], on 09/	23/11 at 10:55, she			In-services for nursing staf	f on	
	1	ent #43 order for a Picc			use and documentation of		
	· ·	inge weekly had not been			non-pharmaceutical	.	
					interventions for residents	who	
	_	the admission orders and			receive psycho active medications Corrective act	iono	
	had not been do	ne as ordered.			will be monitored to ensure		
					practice does not recur by:	tile	
	The policy and p	procedure for Dressing			Social Service staff will		
	Change for Vasc	ular Access Devices			monitor monthly behavior f	low	
	provided by the	DoN on 09/29/11 at 9:00			sheets for occurrence of		
	l ^	" Purpose To prevent			behaviors and presence of		
		ic infection related to the			specific interventions two (2)	
					times per week times six (6		
	IV [intravenous]				months Findings will be		
	_	nbrane dressings are			reviewed by the Performan	ce	
	1 ~ 1	days and PRN [as			Improvement Committee		
	needed].				monthly times six (6) month		
					Completion Date October 2	4,	
	3.1-37(a)				2011		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155670 09/29/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **5233 ROSEBUD LANE** KINDRED TRANSITIONAL CARE AND REHAB-ANGEL RIVER NEWBURGH, IN47630 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Based on the comprehensive assessment of F0318 a resident, the facility must ensure that a SS=D resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. F0318 Based on observation, interview, and F 318 10/24/2011 record review, the facility failed to ensure AngelRiverHealth and Rehabilitation residents with contractures had splints applied according to the plan of care Plan of Correction (Residents #31 and #48), in that Resident **Annual/Complaint** #31 and Resident #48 had carrot splints Survey ordered, but not applied for 2 of 2 Date: September 21, residents sampled for splint use in a 2011 IndianaStateDept of facility sample of #22. Health Findings include: 1.A. The clinical record of Resident #31 **Tag F 318** was reviewed on 09/27/11 at 3:40 P.M. **Corrective Action Take for** The record indicated diagnoses included, those residents found to but were not limited to, dementia and have been affected bone and cartilage disorder. The record further indicated Resident #31 was For resident's #'s 31 and receiving Hospice services. 48 the following actions Resident #31 was identified, on 09/21/11 were taken immediately 11:35 A.M., during the initial tour by UM Physician orders were checked for splint usage [Unit Manager] #1 as not interviewable Care plans and and "having problems with her hands". **Certified Nursing** Resident #31 was observed, at that time, Assistant (CNA) work to be lying in bed with two carrot splints sheets were reviewed for lying at her side, her bilateral hands were

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	I DING	00	COMPL	ETED
		155670	B. WIN			09/29/2	011
		<u> </u>	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEI	R		1	OSEBUD LANE		
KINDRF	D TRANSITIONAL (CARE AND REHAB-ANGEL RIVE	R	1	JRGH, IN47630		
			· ·	L			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
IAU			+	IAU	·		DATE
	observed to be c	ontracted.			accuracy		
					ü Residents were		
	Resident #31 was observed, on 09/27/11				assessed for		
	at 11:10 A.M., up in a wheelchair with no				appropriateness and		
	carrot splints in her hands.				accuracy of splint usag	ge	
	Resident #31 was observed, on 09/27/11						
	at 5:15 P.M., sitting in a geri-chair in the				Other residents having	ı	
		h no carrot splints in her			the potential to be	_	
	hands.	The state of the s			affected by the same		
	indias.				practice;		
	The August 201	1 Physician's Recaps			<u>praotios,</u>		
	1	is not limited to, orders			- All residents havii	20	
	•	-			physician orders for	ıy	
	1	ll times to hands except				·: - I	
	for hand cleanin	g."			splints have the potent		
					for being affected by the	าเร	
	1	contractures, dated			practice and will be		
	1	ed an addendum of			identified by Medical		
	"can't tolerate	hand splintsapproach:			Record Reports		
	change to carrot	s."			For these resident	ts	
					the following actions		
	The most curren	t MDS [Minimum Data			were taken:		
	Set Assessment]	, dated 08/16/11,			ü Physician Orders,		
	indicated Reside	ent #31 had impairment to			CNA worksheets,		
	bilateral upper e	xtremities.			Treatment Records and	d	
					Care Plans were review	ved	
	The undated CN	A [Certified Nursing			for accuracy		
	1	ment sheets Assignment			ü Observations were	•	
	1 -	the DoN [Director of			made to assure accura		
	1	21/11 at 2:00 P.M.,			application of splints a		
	1 0-	Ident #31 was to have			resident compliancy w		
	"therapy carrots				splints		
	l merapy carrots	at all tilles.			opinito		
	.				Manageman west testan et e		
	In an interview v	with UM #1, on 09/28/11			Measures put into place	<u>:e</u>	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DAT			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPLETED
		155670	B. WIN			09/29/2011
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER				OSEBUD LANE	
	O TRANSITIONAL (CARE AND REHAB-ANGEL RIVE	ER		JRGH, IN47630	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
IAG			+	IAG		
	-	indicated Resident #31			and systemic changes	_
		carrots at all times, but "a			<u>made</u>	
	lot of times she throws them."					.
	B. The clinical record of Resident #48				In - service education	·
					nursing staff regarding	·
		09/28/11 at 9:15 A.M.			residents' plan of care	tor
		ated the resident was a			splint placement and	
		and the diagnoses			necessity for following	
	included, but wa	s not limited to,			the care plan	
	Parkinson's.					
					Corrective actions will	
	Resident #48 wa	s identified by RN #1,			monitored to ensure th	<u>ne</u>
	during initial tou	r on 09/21/11 at 11:35			practice does not recu	<u>r</u>
	A.M., as not inte	rviewable and having			<u>by:</u>	
	contractures of the	ne bilateral hands.			_	
	Resident #48 wa	s observed at that time to			DNS, ADNS or designe	ee
	be lying in bed w	vith bilateral upper			will randomly observe	the
	extremity contra	ctures with no splints.			application of splints a	and
	Upon query, at th	nat time, RN #1 indicated			resident compliance tv	vo
	Resident #48 wa	s holding gauze in her			(2) times per week time	es
	contractures.				six (6) months	
					DNS, ADNS or designe	e
	The August 2011	Physician's Recap			will randomly check th	e
	_	s not limited to, an order			Care Plan and CNA wo	
	· ·	wear therapy carrots at all			sheets for accuracy tw	l l
	times"	_T J			(2) times per week time	l l
					six (6) months	
	The most current	MDS [Minimum Data			Findings will be	
	Assessment Set]	-			monitored by the	
		nt #48 had bilateral			Performance	
		e upper extremities.			Improvement Committ	_{ee}
		e upper extremittes.			times six (6) months	
	Dogidant #10	s observed on 09/27/11 at				
					Completion Date	
	U.UU P.IVI., IYING	in bed with bilateral			Completion Date	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155670			ILDING	NSTRUCTION 00	(X3) DATE : COMPL 09/29/2	ETED	
NAME OF	PROVIDER OR SUPPLIE	<u> </u> R	р. үүл		ADDRESS, CITY, STATE, ZIP CODE		
				1	OSEBUD LANE		
		CARE AND REHAB-ANGEL RIVI	=K 	<u> </u>	JRGH, IN47630		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	DATE
	upper extremity	contractures, gauze was					
	observed in her	_			October 24, 2011		
	Resident #48 wa	as observed on 09/28/11 at					
	9:40 A.M., lying	g in bed with bilateral					
	1 **	contractures, gauze was					
	observed in her hands.						
		A assignments sheets					
	Assignment #5, provided by the DoN on						
	09/21/11 at 2:00 P.M., indicated, "extra infothere [therapy] carrot"						
	iniotilete [tilet	apy] carrot					
	1	ted 08/05/10, indicated a ntractures bilateral hands"					
	1 ^	ns which included, but					
	were not limited	to, "keep cloth rolls in					
	hands,"						
	In an interview	with PT [Physical					
	Therapist] #1, or	n 09/28/11 at 10:50 A.M.,					
	she indicated, "F	Resident #48 is supposed					
		ot splints in her hands at					
	all times, except	skin care."					
	In an intervious	with RN #1 on 09/28/11 at					
		indicated, she had just					
		t #48's hands and					
		should have the larger					
	1	nt and the smaller one in					
	1	was then observed to					
		nd point to a large blue					
	1 -	RN #1 was then observed					
	to look throughout	out the room for the					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE S COMPL		
1111212111	or confidence.	155670	A. BUILD B. WING	DING		09/29/20	
	PROVIDER OR SUPPLIER O TRANSITIONAL C	I ARE AND REHAB-ANGEL RIVER	STREET ADDRESS, CITY, STATE, ZIP CODE 5233 ROSEBUD LANE				
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	DI	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	,	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
	"I don't know wh must have thrown indicated, "There now while her had." The Policy and Prof Removable Proprovided by the I.A.M., indicated, splint according to In an interview with 11:05 to 11:05 to 12.	rocedure for Application eformed Splints, DoN on 09/29/11 at 9:00 "a nurse wouldapply a to a physician's order" with Hospice Nurse #1, on 6 A.M., she indicated s to have the carrots in					
F0323 SS=D	environment remainazards as is possible receives adequate devices to prevent Based on observation record review, that of 8 sampled refalls, in the total placed out of read not disable them,	nsure that the resident ins as free of accident sible; and each resident supervision and assistance accidents. ation, interview and e facility failed to ensure esidents reviewed for sample of 22, had alarms to ensure she could so that they would alert of unattended. (Resident	F032	23	F 323 AngelRiverHealth and Rehabilitation Plan of Correction Annual/Complaint Survey Date: September 21, 2011 IndianaStateDept of		10/24/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

MQ3411 Facility ID:

011049

If continuation sheet

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	155670	A. BUI	LDING	00	09/29/2011
		199070	B. WIN	_		09/29/2011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
KINIDDEI	TDANSITIONAL C	CARE AND REHAB-ANGEL RIVE	D	1	OSEBUD LANE JRGH, IN47630	
		·		<u> </u>	JICGI 1, 11147 030	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
TAG	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
IAG		· · · · · · · · · · · · · · · · · · ·		IAG	Health	DATE
	Finding includes	•			пеанн	
	Posidont D's alin	ical record was reviewed			Tag F 323	
		0 p.m. The resident's last			lag F 323	
		-			Corrective estion take	_
	completed full Minimum Data Set [MDS] assessment, dated 6/17/11, indicated she				Corrective action takes for those residents for	 -
	l '					ind
		falls with no injuries.			to have been affected	
		ated 8/23/10, indicated			- For weed don't D. elemen	
		ld turn off and/or hide			For resident D, alarms	
		tions included, but were			were assessed for	
	not limited to, "keep alarms out of reach."				appropriate placement	
					and the resident's leve	el of
		luded, but were not			compliance with the	
	limited to, the fo	•			alarms	
	_	0 a.m.] "Found sitting on			The resident's care pla	
	'	floor mat, next to her			was updated to reflect	
		ioning res., admitted to			type and placement of	
	turning off her pr	-			alarms	
		tory of non-compliance				
	[with] alarms"				Identification of other	
		"Resident states she			residents having the	
		oor this a.m. to BR			potential to be affected	d by
	[bathroom] on bu				the practice and	
	injuryCNA ver				corrective actions take	<u>en</u>
		n., "Resident fall from			-	
	w/c [wheelchair]	into her bedabrasion			Residents who have	
		et (L) [left] knees"			orders for alarms are	
	9/12/11 9:00 a.m	., Incident from 9/11/11			identified by Medical	
	not considered a	fall. Resident had			Record Reports	
	purposeful move	ment from w/c to bed.			All residents who have	•
	Did get abrasions	s on bilateral knees when			physician orders for	
	transferring."				alarms will be assesse	ed
					for appropriateness of	:
	On 9/27/11 at 5:0	05 p.m., Resident D was			alarms and accurate	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	L DIII	LDING	00	COMPLETED
		155670	B. WIN			09/29/2011
			B. WIN		DDRESS, CITY, STATE, ZIP CODE	<u> </u>
NAME OF P	ROVIDER OR SUPPLIER	1		1		
KINDDE	O TO ANOITION AL C	DADE AND DELLAR ANGEL BIVE	_	1	OSEBUD LANE	
KINDREL) TRANSITIONAL (CARE AND REHAB-ANGEL RIVE	K	NEWBU	JRGH, IN47630	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	observed in her v	wheelchair in the hallway.	1		placement and level of	;
		as hanging on the upper			compliance with alarm	
					Care Plans, Treatment	
right handle of the resident's wheelchair,						
	within reach of the resident.				Administration Record	·S,
					Certified Nursing	
	On 9/28/11 at 4:4	45 p.m., Resident D was			Assistant worksheets	of
	observed in her wheelchair, halfway into				all residents who have	
	the resident's bat	hroom in her room. The			physician orders for	
	alarm box was h	anging on the upper right			alarms will be reviewed	d
		eelchair, in reach of the			and updated to reflect	
	resident.	celenan, in reach of the			alarm usage	
	resident.				alailli usaye	
	_	ment sheet, provided by			Measures in place and	-
	the Director of N	Turses on 9/21/11 at 2:00			systemic changes mad	<u>le</u>
	p.m., indicated, f	for Resident D, "keep			to ensure the practice	
	alarm box out of	reach."			does not recur	
	During an interv	iew on 9/29/11 at 10:00			- Nursing staff will be	
	_				in-serviced regarding t	the
	*	r of Nurses indicated the				.iie
		d be kept out of reach of			use of alarms as to	
	the resident.				placement, resident	
					compliance and	
	This federal tag	relates to complaint			appropriateness of the	;
	number IN00096	5312.			alarm	
	3.1-45(a)(2)				Corrective actions will	he
	3.1-43(a)(2)				monitored to ensure th	
					practice does not recu	<u>r</u>
					<u>by:</u>	
					-	
					DNS, ADNS or designe	e
					will randomly observe	
					resident alarm placem	ent
					and resident complian	CE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155670		(X2) MULTIPLE COI A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/29/2011	
	PROVIDER OR SUPPLIER O TRANSITIONAL (CARE AND REHAB-ANGEL RIVER	5233 RO	DDRESS, CITY, STATE, ZIP CODE DSEBUD LANE IRGH, IN47630	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0329 SS=D	Each resident's dr from unnecessary drug is any drug w (including duplicat duration; or without without adequate the presence of acindicate the dose discontinued; or a reasons above. Based on a compresident, the facilit residents who have drugs are not give antipsychotic drug treat a specific cordocumented in the residents who use gradual dose reduinterventions, unlein an effort to discontinued; or a reasons above.	ug regimen must be free drugs. An unnecessary when used in excessive dose therapy); or for excessive at adequate monitoring; or indications for its use; or indications for its use; or indications for its use; or indications of the should be reduced or my combinations of the rehensive assessment of a sy must ensure that the not used antipsychotic in these drugs unless therapy is necessary to indition as diagnosed and antipsychotic drugs receive ctions, and behavioral is clinically contraindicated, continue these drugs. Action, interview, and the facility failed to ensure the ee of unnecessary sident #20, Resident #68, at that residents received	F0329	two (2) times per week times six (6) months Findings will be monitored by the Performance Improvement Committe times six (6) months Completion Date October 24, 2011 F 329 Angel River Health a Administration Plan of Correction Annual/Compla Survey Date: September 2 2011 Indiana State Dept of Health Tag F 329 Corrective	ee 10/24/2011 int 21,

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155670	B. WIN			09/29/2011	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				OSEBUD LANE		
KINDREI	D TRANSITIONAL (CARE AND REHAB-ANGEL RIVE	R	1	JRGH, IN47630		
			· ·			(7/5)	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
		dications without staff			Action Taken for those		
	^ *				residents found to have be	en	
	first attempting nonpharmacologic				affected For resident 20, 68		
	interventions or adequate monitoring for 3				89 the following actions we	ere	
	of 14 residents sampled for psychoactive				taken immediately Nursing		
	medications in the	ne sample of 22.			social services staff asses	sed	
					each for necessity of		
	Findings include	:			medication, behaviors and		
					potential for behaviors Pharmacy consultant and		
	1. The clinical re	cord for Resident #20			resident's physician consu	ultad	
	was reviewed on	09/28/11 at 9:45 A.M.			regarding necessity and	inted	
					appropriateness of medica	tion	
	 Resident #20 wa	s observed on 09/28/11 at			Social Service staff		
	10:00 A.M. lying				implemented behavior		
	10.00 71.111. 191118	s in oca.			monitoring log on resident		
	The same of second	MDC Minimum Data			monitoring logs were pres		
		t MDS [Minimum Data			on resident 68 and residen		
	1	dated 07/07/11 indicated			Care Plans were update	ted	
		s moderately cognitively			to reflect specific non		
	1 1	IDS further indicated a			pharmaceutical		
	behavior of hittir	ng had been identified.			interventions		
					_		
		y the DoN on 09/27/11 at			Nursing staff instructe	d	
	10:30 A.M. inclu	ided a handwritten			to document specific i	non	
	Physician's order	dated 04/22/11			pharmaceutical		
	l -	ril 25 mg [milligram] by			interventions attempte	ed	
	· ·	ce daily as needed			to avert behavior befo	I	
	aggitation [sic]/a	-			administering medicat		
		<u>, </u>					
	 The MAR [Medi	cation Administration			- Identify other resident	<u> </u>	
	_	l 2011 indicated Vistaril					
	_ ^				having the potential to	, ne	
		given twice on 04/23/11,			affected by the same		
		1, and once on 04/28/11.			practice and corrective	e	
		MAR on the Nurse's			actions taken		
		s included, but was not			Identify other residents ha	- 1	
	limited to, the fo	llowing notations:			the potential to be affected	by	

011049

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155670	B. WIN			09/29/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF 1	PROVIDER OR SUPPLIEF	8			OSEBUD LANE		
KINDRE	D TRANSITIONAL (CARE AND REHAB-ANGEL RIVER	!		JRGH, IN47630		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	"04/23/11 at 094 mg by mouth for Response sleepin 04/24/11 at 0730 mg by mouth for response docume 04/24/11 2100 [9 by mouth for no documented]" 04/28/11 0530 [5 by mouth for atte of bed] and increases response: up in 0630 [6:30 A.M. The Nurse's Med documentation fl Vistaril was adm. The Nurse's Note entries: "04/23/11 0345 [Vistaril at MN [r nurse to help with lacked any documentation flow of the properties of the pro	10 [9:40 A.M.] Vistaril 25 Tyelling/anxious Ing 10:30 A.M. 10 [7:30 A.M.] Vistaril 25 Tyelling/anxious[No ented]" 10:00 A.M.] Vistaril 25 mg sleeping[No response 10:30 A.M.] Vistaril 25 mg sleeping[No response 10:30 A.M.] Vistaril 25 mg empting to get OOB [out eased agitation chair, decreased agitation 1]" 11 dication Notes lacked any hat more than one dose of ainistered on 04/23/11. 12 included the following 13:45 A.M.]Refused 14 indinght] as offered by 15 ch anxiety." The note 16 mentation that 17 included the medication was 18 included the medication was 19 included the medication was			the same practice and corrective actions taken All residents receiving psycho active medications are identified by Medical Recor Reports Chart reviews will be completed for all residents receiving psycho active medications for: appropriate diagnosis, non-pharmaceut interventions, and monthly behavior monitoring flow sleed Measures put into place and systemic changes to ensure the practice does not recur ln-services for nursing staff use and documentation of non-pharmaceutical interventions for residents receive psycho active medications Corrective active social Service staff will monitor monthly behavior for sheets for occurrence of behaviors and presence of specific interventions two (times per week times six (6 months Findings will be reviewed by the Performance Improvement Committee monthly times six (6) month Completion Date October 2 2011	d be le tical heet d e f on who ions the flow 2))	
		gical interventions were					
	attempted before	e the medication was					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155670	B. WIN			09/29/2	011
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	OSEBUD LANE		
KINDREI	O TRANSITIONAL C	CARE AND REHAB-ANGEL RIVE	R	1	JRGH, IN47630		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	administered.						
	"04/24/11 10:15	[1:;15 A.M.]prn					
	Vistaril given as needed" The note						
	lacked any docur						
		ical interventions were					
		the medication was					
	administered.	me medication was					
	administered.						
	The Name - No.	an looked one fourth an					
	The Nursing Notes lacked any further						
		n 04/24/11 related to the					
	Vistaril.						
	W04/20/11 0600 F	COO A MID					
	-	6:00 A.M.] Resident					
		ox [approximately] 1 1/2-					
	2 hrs [hours] and	was given Visteril [sic]					
	25 mg by mouth	d/t [due to] while up in					
	wheelchair attem	pting to scoot down out					
	of chair with bed	alarm sounding. While					
	in room kept atte	mpting to sit on side of					
	bed causing alarr	n to sound. While					
	_	t nurse's station and this					
	_	to reposition legs pulled					
		ated, "do something with					
		ed juice and consumed					
		juiceAfter Visteril [sic]					
		ered] became quiet and					
	napped for very						
	napped for very s	snort periou.					
	Δ fay to the nhyo	sician, dated 04/25/11 was					
		DoN on 09/28/11 at 10:30					
		ed, "Fam. [Family]					
		inge Visteril [sic] to BID					
	[twice daily] rou	tine instead of prn [as					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155670	B. WIN			09/29/2	011
		1	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R		1	OSEBUD LANE		
KINDRE	D TRANSITIONAL	CARE AND REHAB-ANGEL RIVE	R	1	JRGH, IN47630		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	needed]. Says th	ey see an improvement					
	[sic] since started" The physician's						
	response include	ed had handwritten order					
	1 ^	mg [milligram] by mouth					
	· ·	y as needed aggitation					
	[sic]/anxiety"	y us needed aggination					
	[Sic], anxiety						
	The Perident Progress Notes dated						
	The Resident Progress Notes dated 04/20/11 through 04/30/11 were reviewed						
	and lacked any S						
		The clinical record					
	1	mentation of a plan of					
	care for behavio	rs.					
	To an intention	14. 4 GCD [G 1					
		with the SSD [Social					
	1	ee] on 09/28/11 at 4:45					
		ed, "Psychoactive					
	_	rd, not found on [name of					
	Resident #20]."						
		id d. D. MEDI					
		with the DoN [Director of					
	T = 2	28/11 at 12:10 P.M. she					
	_	le interventions were					
	attempted prior	to receiving the prn					
	Vistaril order, bu	ıt a formal plan had not					
	been created. The	he DoN further indicated					
	at that time that	Resident #20 had later					
	been treated for	a UTI [urinary tract					
		as no longer exhibiting					
	the behaviors.						
	In an interview v	with the HFA [Health					
		nistrator] on 09/28/11 at					
		dicated, "As far as a					
	+.45 F.IVI. SHE III	uicaicu, As iai as a					

	OF CORRECTION	IDENTIFICATION NUMBER:	Ì		NSTRUCTION 00	COMPI	
1111212111	or continuenton	155670	1	ILDING		09/29/2	
			B. WI		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	1		1	OSEBUD LANE		
KINDREI	D TRANSITIONAL (CARE AND REHAB-ANGEL RIVI	ĒR	1	JRGH, IN47630		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCE!)		DATE
	behavior plan, it	s just not there.					
	The Delieve and I	Den andrema for					
	The Policy and F	ug Use provided by the					
	l -	1 at 09:00 A.M. indicated,					
		Implement a behavior					
		or similar mechanisms to					
		For and response to drug					
		tify evidence for other					
	1	for the patient's distress					
	1 ^	ered and ruled out. This					
		is not limited to" a.					
	pain	is not minted to u.					
	1 ^	ronmental stressors					
		nosocial stressors					
	I	able medical conditions					
	e. Infec						
		rnative methods to					
	_	g use and document					
	effectiveness						
	15. Collaborate	with the physician in					
	considering whe	ther the current					
	medication, dose	e, and duration (e.g.					
	medication was i	initiated as a result of a					
	time-limited con						
	infection and the	n should be					
	l '	appropriate or should be					
	reduced, change	d, or					
	discontinuedDo	ocumentation					
	Guidelines4. I	Document evaluation of					
	1 ^	to psychoactive drug,					
	effectiveness of	psychoactive drug, dose					
	`	tiveness or failure), factor					
	and/or complicat	tions related to					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	155670	- 1	LDING	00	09/29/2	
		100070	B. WIN		DDDEGG CITY CTATE ZID CODE	03/23/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE OSEBUD LANE		
KINDREI	D TRANSITIONAL C	CARE AND REHAB-ANGEL RIV	ER	1	JRGH, IN47630		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		g use. Update care plan					
	as needed"						
	2 Resident #68's	s clinical record was					
		5/11 at 9:30 a.m. The					
		ses included, but were					
		emia, hypertension,					
	l '	ner's disease, anxiety and					
	depression.						
	1						
	Review of the M	edication Administration					
	Record [MAR] for	or September, 2011, at					
	the time of the re	cord review, indicated					
	Ativan 0.25 milli	grams [mg] was					
	administered on	the following dates and					
	times, for "yellin	g, agitated,"					
	' - '	" "screaming," or					
	"anxiety [increas	-					
	9/1/11 1:30 p.m.						
	9/1/11 10:40 p.m	l.					
	9/2/11 2:30 p.m.						
	9/5/11 9:00 p.m.						
	9/8/11 8:00 p.m.						
	9/11/11 8:30 p.m						
	9/13/11 9:30 p.m						
	9/18/11 5:00 p.m 9/19/11 9:30 a.m						
	9/19/11 9:30 a.m 9/25/11 9:00 p.m						
	<i>9/23/11 9.</i> 00 p.m	i .					
	Review of the M	onthly Behavior					
		sheet and nurses' notes					
	_	011, indicated the					
		entions documented as					
	· -	above dates and times:					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	ETED
		155670	B. WIN			09/29/20)11
					ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF F	PROVIDER OR SUPPLIER				OSEBUD LANE		
KINDREI	D TRANSITIONAL C	CARE AND REHAB-ANGEL RIVE	R		JRGH, IN47630		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	9/1/11 redirection	n					
	9/2/11 none						
	9/5/11 redirection						
		n and one to one care					
	9/11/11 none						
	9/13/11 redirection	on, one to one care,					
	medication						
	9/18/11 none						
	9/19/11 redirection	on, medication					
	9/25/11 redirection						
	Also noted in the	e clinical record, the					
	l '	ted on an antibiotic for					
	pneumonia on 9/						
	pineumomu on 57	10/11.					
	The resident's car	re plan, dated 9/7/2009,					
	indicated a problem	_					
	1 ^	anxious behaviors at					
	times "yells out a						
		at times-has had overall					
		state." Interventions					
	· · · · · · · · · · · · · · · · · · ·	re not limited to, the					
	following:						
		sident during stressful					
	periods and repor						
	Set up a consister	nt schedule for daily					
	care						
	Provide positive	reinforcement when not					
	anxious.						
	Assess and docur	ment frequency of					
	anxiety.						
	I -	contributing factors					
	_	iety and intervene as					
	needed.	,					
	nocaca.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155670		(X2) MULTIP A. BUILDING B. WING		OO	(X3) DATE S COMPL 09/29/2	ETED	
	ROVIDER OR SUPPLIER	CARE AND REHAB-ANGEL RIVER	STREET ADDRESS, CITY, STATE, ZIP CODE 5233 ROSEBUD LANE				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	Allow to cry. Recall Daughter if Administer meds Assess for S/S [s infection and obt Rule out pain, hu Nurses' notes inclimited to, the for 9/5/11 10:00 a.m down for a nap to the unsuccessfulRecout of here, I'm grayou." 9/5/11 1:50 p.m., back down after encourage res. bu 9/5/11 2:00 p.m. down again res. it mins res. started spelling out letter redirect res. but w 9/6/11 12:00 mid resident was in h loudly, 'gotta get 1 X's multiple att Routine 2400 [m mg [antianxiety radministered as coalm, but refusin Given magazine	igns/symptoms] of ain labs as ordered. ingar (sic), thirst." luded, but were not llowing: ., "Res. refused to lay ried to redirect res. es. yelling 'I want to get roing to tell my Daddy on "Res. refused to lay meal and tried to at she still saying 'No'" "Attempt to lay res. n agreement after 30 yelling real loud and rs of the alphabet tried to wasn't successful." Inight, "Upd/t [due to] er bed and kept yelling up' over and over. 1 on rempts non-successful. idnight] med (ativan 0.5 medication]) ordered. Appeared more g to go back to her bed. et a snack." "Resident has refused to					

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Event ID:

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		Ì		INSTRUCTION 00	(X3) DATE COMPL		
		155670	B. WIN	LDING NG		09/29/2	011
	PROVIDER OR SUPPLIER		-	5233 R	ADDRESS, CITY, STATE, ZIP CODE OSEBUD LANE		
		CARE AND REHAB-ANGEL RIVE	:K	NEWBO	JRGH, IN47630		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
1.10		s screaming loudly 'I'm	<u> </u>	0			D.H.E
		e police on you.' Noted					
	~	ety and when this writer					
	-	ting yells out -" yes all					
		where." PRN [as needed]					
	1	lication] and PRN ativan					
	administered @ t						
	9/8/11 2400, "[in	creased] anxiety, yelling					
	out in bed. Rout	ine Ativan and PRN					
	Lortab administe	red at the time."					
	9/9/11 9:30 a.m.,	"Res. assisted to bed,					
	res. started yellin	g et crying stating, 'I					
	I -	, I want to get up.' Tried					
		nsuccessful notify M.D.					
		d [increase] Risperdal					
		edication] to T.I.D. [three					
	times a day."						
		., "Yelling out, offered					
	~	andwich, consumed					
	100% with assist						
		, 80 ml H2O [water], will					
	monitor."	"Dogting in had [41]					
	9/12/11 2:55 a.m eyes closed, no s	., "Resting in bed [with]					
	cyes closed, 110 s	15 OI UISHESS.					
	Social Service no	otes included, but were					
	not limited to, the	e following:					
	9/7/11 [no time]	"met with resident's					
	[family] re: rece	nt [change] in					
	mood/behavior a	nd med [medication]					
	reviewDiscusse	ed possible progression					
	and options of [in	npatient psychiatric unit]					
	_	physician feels he is					
	unable to manage	e her @ facility."					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

MQ3411 Facility ID:

011049

If continuation sheet

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´		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155670	A. BUILDING	00	09/29/2011
		133070	B. WING	PRESIDENCE CONTROL CON	09/29/2011
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE OSEBUD LANE	
KINDREI	D TRANSITIONAL C	CARE AND REHAB-ANGEL RIVER		JRGH, IN47630	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
] "She has had a			
	" " "	d/behavior since last			
		e has been restless,			
	l -	outShe will become			
	· ·	'I want to go home,' or			
		father/mother and thinks			
	they have left her	•			
	-	nedicine to Risperdal.			
	This has been eff	• •			
		as been less alert early in			
		ng to nursing, however,			
		ert as the morning goes			
	I	She also utilizes Ativan			
	for anxiety"				
	Nurses' notes cor	ntinued:			
	9/16/11 10:00 p.r	m., Res. very agitated -			
	yelling and cryin	g - Ativan given for			
	agitation [and] L	ortab for c/o [complaint			
	of] pain - Sleepin	ıg."			
	9/17/11 6:00 p.m	., "[Family] concerned			
	that pt. isn't as 'al	lert' today"			
	9/18/11 Conditio	n Change Form, [no			
	time], CXR [ches	st x-ray] results indicate			
	pneumonia - rec'o	d [received] order for			
	[antibiotic]"				
	9/19/11 9:30 a.m	., "Res. yelling and			
	crying wanting to	leave - tried to redirect			
	res. unsuccessful	gave Ativan 0.25 mg per			
	M.D. order."				
	9/23/11 9:00 p.m	., "Quiet most of the shift			
	- did cry out for a	a short while after going			
	to bed, but not fo	or long."			
	9/24/11 10:30 p.r	n., "Yells out loudly @			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	IULTIPLE CO	NSTRUCTION 00	(X3) DATE ST COMPLE		
ANDILAN	or conduction	155670	- 1	LDING		09/29/20	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	1 00:20:20	
NAME OF F	PROVIDER OR SUPPLIER			1	OSEBUD LANE		
KINDREI	D TRANSITIONAL (CARE AND REHAB-ANGEL RIVE	R		JRGH, IN47630		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG				TAG	DETCIENCT)		DATE
	' "	kies/milk [with] good					
	errect, demes par	n, will observe"					
	3 Resident #89'	s clinical record was					
		3/11 at 10:15 a.m. The					
		ses included, but were					
		story of urinary tract					
	infections, hyper						
	, , , ,	of delirium, anxiety and					
	depression.	, ,					
	•						
	The resident had	a care plan, dated					
	9/17/11, for anxi	ety. The interventions					
	included, but we	re not limited to, the					
	following:						
	"Find a calm, qui	iet environment.					
	Reassure during	interactions by touch and					
	verbal/non verba	l exchanges.					
	Assess for drugs	which cause anxiety.					
	Administer medi	cation as					
		r effectiveness [and] side					
	effects.						
		dent during stressful					
	periods and repor						
	Hospice to assess						
	Obtain labs as or	dered."					
	Review of the Se	entember, 2011					
		inistration Record					
		Ativan [anti-anxiety					
		nilligrams [mg] was					
	I -	owing dates and times for					
	"anxiety:"						
	9/18/11 12:00 no	on					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	MULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	155670	A. BUI	ILDING	00	09/29/2	
		133070	B. WIN		DDDDGG GWW GWW GWD	03/23/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	DSEBUD LANE		
KINDREI	D TRANSITIONAL C	CARE AND REHAB-ANGEL RIVE	R	1	JRGH, IN47630		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	\neg	ID	PROVIDENCE N. A.V. OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
	9/21/11 8:00 p.m						
	9/22/11 4:30 a.m						
	9/22/11 6:00 p.m						
	9/26/11 4:00 p.m						
	Nurses' notes inc	luded, but were not					
	limited to, the fol						
	l '	n., "Agitation noted this					
	shift"	n., Agration noted this					
		Condition Change					
		y request MD ordered					
	UA C + S [urinal	•					
	sensitivity]."	ysis, cuitare and					
		., "Initial dose of Atb					
	1	edrestless up in w/c					
		eve [evening] meal"					
		., "ATB UTI [urinary					
	1	ontinues resident restless					
	_	ssisted to bed resting					
	[with] eyes close	· ·					
		., "Tearful @ times this					
		plaint of pain, Lortab					
	^	effective. Ativan given					
		nxiety helpful alarm					
	placed"	inicity neipiui alailii					
	_	n., "ATB UTI continues					
		this AM. Ref. [refused]					
	~	in recliner speech					
		stand @ times but able to					
		ted to go back to bed					
	assisted"	ica io go back io bea					
		., "Noted N.O. [new					
	1	hin [antibiotic] 1 gm					
	^	2 2					
	[grann] nvi [intrai	muscularly] qd [daily] X					

011049

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		,		NSTRUCTION 00	(X3) DATE S COMPL		
		155670	A. BUIL B. WINC			09/29/2	
	PROVIDER OR SUPPLIER O TRANSITIONAL C	I CARE AND REHAB-ANGEL RIVER	·	STREET A	DDRESS, CITY, STATE, ZIP CODE OSEBUD LANE JRGH, IN47630		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	-	ID		1	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL]	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		I a Monthly Behavior sheet for September,					
	2011. The target	behavior identified on					
	the flowsheet wa	s "S/S [signs/symptoms]					
	Depression." The	ere was no monitoring					
	for anxiety, no do						
		empted prior to using the					
	anti-anxiety med	ication.					
	2.1.40(.)(2)						
	3.1-48(a)(3)						
	3.1-48(a)(4)						
F0333 SS=D		nsure that residents are ant medication errors.					
	Based on record	review and interview, the	F03	333	F 333		10/24/2011
	facility failed to	ensure residents receiving			AngelRiverHealth and		
	insulin were free	of significant medication			Rehabilitation		
	`	#14), in that Resident			Plan of Correction		
		ordered at bedtime and it			Annual/Complaint		
	-	r 26 days, for 1 of 2			Survey Date:		
	•	d for receiving insulin in			September, 21, 2011		
	a facility sample	of 22.			IndianaStateDept of		
	Dindings to 1 1				Health		
	Findings include:				Corrective action taker	,	
	The clinical reco	rd of Resident #14 was			for those residents fou		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

MQ3411 Facility ID:

011049

If continuation sheet

Page 34 of 47

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	IULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
THETETAL	or conduction	155670		ILDING		09/29/2011
		100010	B. WIN		ADDRESS CITY STATE ZID CODE	00/20/2011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE OSEBUD LANE	
KINDREI	O TRANSITIONAL (CARE AND REHAB-ANGEL RIVE	-R		JRGH, IN47630	
		-	-1`\			1 275
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
		22/11 at 2:15 P.M. The	1		to have been affected	
		the diagnoses included,			to have been allested	
		ited to, Diabetes Type II.			- Actions taken for	
	out were not min	ned to, Blabetes Type II.			Resident # 14	
	The August 2011	Physician's Order Recap			immediately were:	
	_	s not limited to, and order			Assessed for adverse	
	for:	s not innited to, and order			reactions	
		g scale coverage QID			Diabetic flow sheets w	vere
] -before meals and at hs			reviewed to assess for	
	[hour of sleep]:] before means and at his			accuracy in medication	
	<pre> (less than) 70=</pre>	No coverage			administration and blo	
	70-150=2 units	110 coverage			sugar levels	
	201-250=4 units				Medication Administra	ition
	251-300=6 units				Record was reviewed	
	301-350=8 units				accuracy in	
	351-400=10 unit	8			administration of	
		400=10 units and call MD			medications	
	[physician]	100 TO units and can MD			Medical record was	
	Use half dose at 1	hs "			reviewed for	
		Physician's Order Recap			documentation of the	
	_	a handwritten note signed			med error and	
		dated 08/04/11 which			appropriate follow up	at
	J 1 J	Lantus 10 units at hs"			the time of the med en	
	marcaica, built	Land to anno at no				
	The August 2011	Medication			Other residents having	,
	_	Record [MAR] lacked any			the potential to be	^
		nat Lantus 10 units was to			affected by the same	
	be given at bedting				practice:	
	55 51 on at 55 att	··········			<u> </u>	
	The Diabetic Mo	onitoring Flow Sheets for			Residents who have	
		icated Resident #14			Insulin orders are	
	_	ated blood sugars on the			identified by Medical	
	*	and received insulin per			Records Reports	
	the ordered slidir	•			All residents receiving	,
	Life Ordered Sildii	15 50010 .				<u> </u>

STREET ADDRESS, CITY, STATE, ZIP CODE 5233 ROSEBUD LANK KINDRED TRANSITIONAL CARE AND REHAB-ANGEL RIVER STREET ADDRESS, CITY, STATE, ZIP CODE 5233 ROSEBUD LANK NEWBURGH, INAT630 OR 307 LANGE COMPLETION DATE OR 308 AND STREET ADDRESS, CITY, STATE, ZIP CODE 5233 ROSEBUD LANK NEWBURGH, INAT630 OR 307 LANGE COMPLETION DATE OR 308 AND STREET ADDRESS, CITY, STATE, ZIP CODE 5233 ROSEBUD LANK NEWBURGH, INAT630 OR 307 LANGE COMPLETION DATE OR 308 AND STREET ADDRESS, CITY, STATE, ZIP CODE 5233 ROSEBUD LANK NEWBURGH, INAT630 OR 307 LANGE COMPLETION DATE OR 308 AND STREET ADDRESS, CITY, STATE, ZIP CODE 5233 ROSEBUD LANK NEWBURGH, INAT630 OR 308 AND STATE	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155670		l ,	IULTIPLE CO	NSTRUCTION 00	(X3) DATE SURV COMPLETEI 09/29/2011		
SAURO PROVIDER OR SUPPLIES			155070	B. WIN			09/29/2011	
INDRED TRANSITIONAL CARE AND REHAB-ANGEL RIVER NEWBURGH, IN47630	NAME OF I	PROVIDER OR SUPPLIE	R					
PREFIX TAG REGULATORY OR I.SC IDENTIFYING INFORMATION DATE	KINDRE	D TRANSITIONAL	CARE AND REHAB-ANGEL RIV	ER	1			
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCE OF The APPROPRIATE DATE								
Single Content of State (State Content of State Content		` `				CROSS-REFERENCED TO THE APPROPRIA	TE CO	
08/13/11 at 5:00 P.M.= 463 08/3/11 at 7:00 P.M.= "high" 08/20/11 at 4:00 P.M.=467 08/27/11 at 8:00 P.M.=467 A Physician's Telephone Order dated 08/06/11, no time, indicated, "give 15 u [units] of Novolog now-recheck blood sugar in 2 hours-Notify MD if blood sugar > 300." A Physician's Telephone Order dated 08/13/11 at 5:30 P.M. indicated, "Recheck BS [blood sugar] in 2 hoursGive total of 15 u Novolog now." A Physician's Telephone Order dated 08/13/11 at 7:30 P.M. indicated, "Give 20 u Novolog now" A Physician's Telephone Order dated 08/3/3/11 at 7:30 P.M. indicated, "Give 20 u Novolog now" A Physician's Telephone Order dated 08/27/11 at 8:30 P.M. indicated, "Give 20 u Novolog now-recheck in 2 hours-if over 400 notify MD again." A Unit 100 Fax dated 08/30/11 indicated, "Noted N.O. [new order] 08/04/11 Lantus 10 units at HS [sic] resident did not receive this medication all mo [month]" A Medication Variance Report Worksheet provided by the DoN [Director of	IAG			-	IAG			DATE
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10 units at HS [sic] resident did not receive this medication all mo [month]" A Medication Variance Report Worksheet provided by the DoN [Director of Done			· · · · · · · · · · · · · · · · · · ·					
receive this medication all mo [month]" The DNS, ADNS or designee will do random provided by the DoN [Director of checks (2) times per week			-				-	
A Medication Variance Report Worksheet provided by the DoN [Director of The DNS, ADNS or designee will do random checks (2) times per week		-	-			~1.		
A Medication Variance Report Worksheet provided by the DoN [Director of Checks (2) times per week		i receive uns med	neation an mo [montin]			- The DNS, ADNS or		
provided by the DoN [Director of checks (2) times per week		A Medication Va	ariance Report Worksheet				m	
			*			_		
		1 *	-			times two (2) months a	I .	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155670			A. BUI	LDING	onstruction 00	(X3) DATE SURVEY COMPLETED 09/29/2011
		100010	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/20/2011
NAME OF I	PROVIDER OR SUPPLIER	₹		1	OSEBUD LANE	
		CARE AND REHAB-ANGEL RIVER	₹	NEWBL	JRGH, IN47630	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL SELSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
IAG	indicated, "Lanti	· · · · · · · · · · · · · · · · · · ·	<u> </u>	IAU	then monthly times six	
	1	nAdverse Drug			months for those	(0)
	1	•			residents who receive	
		Type of Effects observed ner" with a handwritten			insulin. The clinical	
	_					
		ed, "increased blood sugar			records will be checke for:	"
	1 -	eased coverageType of sion" with a handwritten			Physician orders	
		ed, "Transcription			Accurate and timely	
		[received] 8-4-11 not			transcription of orders	
		edication Errors Severity			Accurate and timely	
		Iarm Category E- An			administration of the	
	_				medication	
		nat may have contributed temporary harm to the			The Performance	
					Improvement Committ	••
	_	uired intervention." A			-	
		ntion in the right margin			will monitor findings o	
		t indicated, "[name of			random checks month	^{iy}
	1 ^ -	e order on pink order sheet			times six (6) months	
		[telephone order] Wrote it			Completion Date	
	on 3rd page inste	ead of last."			Completion Date	
	A Care Plan date	ed 04/20/11 for Type II			October 24, 2011	
	Diabetes include	ed approaches which				
	included, but wa					
	· ·	dications as ordered."				
	In an interview v	with the DoN on 09/23/11				
	at 10:55 A.M. sh	ne indicated, "[name of				
		l not get the insulin				
	_	er was not transcribed to				
	the MAR."					
	3.1-25(b)(9)					
	3.1-48(c)(2)					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155670		(X2) MULTIP A. BUILDING B. WING		OO	(X3) DATE S COMPL 09/29/2	ETED	
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
KINDRED TRANSITIONAL CARE AND REHAB-ANGEL RIVE			•		SEBUD LANE RGH, IN47630		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREF	- 1	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	Έ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAC	j	DEFICIENCY)		DATE
F0441 SS=E	Infection Control P a safe, sanitary an and to help preven transmission of dis (a) Infection Control The facility must e Program under wh (1) Investigates, co infections in the fa (2) Decides what p isolation, should be resident; and (3) Maintains a rec corrective actions (b) Preventing Spr (1) When the Infect determines that a prevent the spread must isolate the re (2) The facility must communicable disc lesions from direct their food, if direct disease. (3) The facility must hands after each of which hand washin professional practic (c) Linens Personnel must has	stablish an Infection Control nich it - controls, and prevents cility; procedures, such as e applied to an individual cord of incidents and related to infections. read of Infection ction Control Program resident needs isolation to d of infection, the facility esident. st prohibit employees with a ease or infected skin contact with residents or contact will transmit the st require staff to wash their direct resident contact for ng is indicated by accepted					

I 155670		(X2) M A. BUII B. WIN	LDING	ONSTRUCTION 00	(X3) DATE (COMPL 09/29/2	ETED	
NAME OF F	PROVIDER OR SUPPLIEF	II	P. (12)	STREET.	ADDRESS, CITY, STATE, ZIP CODE		
KINDREI	O TRANSITIONAL (CARE AND REHAB-ANGEL RIVER	2	I	OSEBUD LANE URGH, IN47630		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	G REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
		ation, interview, and	F0	441	F 441 Angel River Health a	nd	10/24/2011
	record review, th	ne facility failed to ensure			Rehabilitation Plan of Correction Annual/Compla	int	
	policies and prod	cedures for infection			Survey Date: September		
	control were imp	olemented for 4 of 8			2011 Indiana State Dept of	,	
	sampled resident	ts observed for			Health Corrective action ta	ken	
	medications, trea	atments/dressing changes,			for those residents found t	<u>o</u>	
		the sample of 22, in that a			have been affected		
	•	erted Central Catheter			Resident # 43 the following	9	
		sing was not changed as			actions were taken		
		vere not washed between			immediately:		
		administered medications,			The physician order was checked		
	_	e was done in a way that			The PICC line dressing was		
	*	•			changed following physicia		
	•	at risk for infection.			order		
	(Residents #43,	#8, #20, #118)			The PICC line site was		
					assessed for signs and		
	Findings include	e:			symptoms of infection		
					The physician was notified		
	1. The clinical r	record of Resident #43			Resident # 's 8 and 20 the following actions were take	\n	
	was reviewed on	n 09/22/11 at 10:15 A.M.			immediately:	711	
	The record indic	ated, the diagnoses,			Observations were made for	or	
	included, but wa	s not limited to, DVT			adverse reactions to the		
	[Deep Vein Thro	ombosis] and malnutrition.			omission of hand washing		
		•			between the two residents		
	Resident #43 wa	s identified by the UM			RN # 2 was counseled		
		#1 on 09/21/11 at 12:15			regarding the facility policy infection control principle		
		ial tour as interviewable.			hand washing between)i	
		The state as interviews to the state of the			resident contact		
	A Physician talo	phone order dated,			Resident # 118 the followin	g	
		e indicated, included an			actions were taken	-	
					immediately:		
		cc [an intravenous			Observations were made for	or	
	_	10 cc NS [normal saline]			any adverse reactions		
	every shift 2. ch	nange dressing			Perineal care was given		
	weekly-Picc."				following facility policy and infection control principles		
			1		infection control principles		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COM			COMPLETED	
		155670	B. WIN			09/29/2011	
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			OSEBUD LANE		
KINIDDEI	TDANCITIONAL (CARE AND REHAB-ANGEL RIVE	5	I	JRGH, IN47630		
KINDKEI	J TRANSITIONAL (CARE AND REHAB-ANGEL RIVER	`	NEWBO	JRGH, IN47630		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	· ·	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		TION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)	DATE	
	The Care plan for	or the Picc included, but			CNA # 1 was counseled		
	was not limited t	to, approaches, "change			regarding the necessity of		
	dressing weekly.	"			following facility policy and		
					infection control principles		
	Resident #43 wa	s observed on 09/22/11 at			when giving perineal care Other residents having the		
		g in the chapel. A Picc line			potential to be affected by t	he	
	_	served to be intact on the			same practice:	''	
					All residents who receive		
	right arm and da	ted 09/11/11.			peritoneal care, have PICC		
					lines and are given		
	Resident #43 wa	as observed on 09/23/11			medications have the poter	tial	
	at 9:45 A.M. sitt	ing in her room. A Picc			to be affected. For those		
	line dressing wa	s observed to be intact on			residents the following acti	ons	
	the right arm dat	red 09/11/11.			have been taken:		
	S				Infection control data has b	een	
	The policy and r	procedure for Dressing			reviewed to assess for	.	
		· ·			trends/patterns of increase	l l	
	_	ular Access Devices			Urinary Tract infections and other infectious processes,	l l	
	•	DoN [Director of			respiratory, gastrointestina	l l	
		29/11 at 9:00 A.M.			etc.	''	
	indicated, " Purp	ose To prevent local and			In - services on necessity for	or	
	systemic infection	on related to the IV			hand washing after each		
	[intravenous] sit	e. Policy2. Transparent			patient contact have been		
	membrane dress	ings are changed every			presented to all nursing sta	ff	
	7 days and PRN				who administer medication	s	
	,,	[In – services on peritoneal	l l	
	In an interview v	with the DoN on 09/23/11			and necessity to use infect	l l	
					control methods according	to	
		cated, the admission			facility policy have been		
		c line dressing change			presented to all nursing sta who give peritoneal care	"	
		nsposed and had not been			In – services on PICC line		
	done as ordered.				dressing changes and infe	tion	
					control principles have bee	l l	
	2. During the ob	oservation of a medication			presented to all licensed		
	_	1 at 4:20 P.M., RN #2			nursing staff		
	* ′	prepare and administer			Corrective actions will be	[
					monitored to ensure the		
medication to Resident #8. RN #2 was		1			ı		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155670	B. WIN			09/29/2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	8				
KINDDE	D TD ANOITIONIAL A	DADE AND DELLAD ANGEL DIVE		1	OSEBUD LANE	
KINDREI	D TRANSITIONAL (CARE AND REHAB-ANGEL RIVER	Κ	NEWBO	JRGH, IN47630	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	then observed to	touch the forearm of			practice does not recur by:	
	Resident #8_RN	#2 was then observed to			The Staff Development	
		inister medications to			Coordinator, DNS or ADNS	
	^ ^				and/or designee will observ	/e
	`	mpled resident) without			two (2) medication passes	per
	performing hand	lwashing.			week times six (6) months	
					The Staff Development	
	The policy and p	procedure for Hand			Coordinator, DNS, ADNS	
	Hygiene/ Handw	ashing provided by the			and/or designee will observ	• • • • • • • • • • • • • • • • • • •
	'	1 at 9:00 A.M. indicated,			peritoneal care being given	
		nd Hygiene is to be			(2) times per week times six	(6)
	· ·				months	
	performedbetw	veen patient contacts"			The Staff Development	
					Coordinator will Collect and	,
	In an interview v	with RN #3 on 09/27/11 at			Analyze monthly Infection Control data to identify	
	4:30 P.M. she in	dicated, "We are to wash			increased infections	
	hands before eve	ery patient "			Infection Control findings a	and .
		and passesses			results of observations will	
					reviewed by the Performan	
					Improvement Committee	
					monthly times six (6) month	ns
					Completion Date	
					October 24, 2011	
	3. On 9/27/11 at	t 10:15 a.m., Resident			,	
		red laying in bed. She				
		urting on her bottom.				
	1 ^	•				
		as activated and CNA #1				
	· ·	ht. CNAs #1 and #2 were				
	observed cleansi	ng the resident and				
	changing the resident's incontinence brief.					
		s observed to have a				
		she had been incontinent				
	· -	e brief. CNA #1 initially				
		dent's buttocks and anal				
	area. The buttoo	eks and anal area were				
	observed to be re	eddened. CNA#1				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					INSTRUCTION 00	(X3) DATE : COMPL	
		155670	1	LDING		09/29/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				OSEBUD LANE		
KINDRED TRANSITIONAL CARE AND REHAB-ANGEL RIVER			R	1	JRGH, IN47630		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		and washed her hands.					
	•	led to cleanse the front					
	•	he resident. She used a					
	wash cloth with	soap on it, reached					
	between the resid	lent's legs and washed					
	from the back of	the perineal area to the					
	front, where the	catheter exited the					
	urethra. She was	shed from back to front,					
	then rinsed from	back to front.					
	Resident #118's	clinical record was					
	reviewed on 9/27	7/11 at 11:00 a.m. The					
		ses included, but were					
	_	emia, heart failure,					
	history of urinary						
		y, and a history of					
	· ·	icile infection. The					
		rently receiving Flagyl					
		ication] and Vancomycin					
	[antibiotic] for cl						
	Clostridium Diff	icile, a bowel infection.					
		Nurses [DoN] provided a					
		edure for Perineal Care					
		esident, dated 4/28/07,					
	on 9/29/11 at 9:0	0 a.m. The procedure					
	included, but was	s not limited to, the					
	following instruc	etion:					
	"Gently cleanses	the pubic area:					
	a. Uses one glov	red hand to stabilize and					
	separate the labia	and use the other hand					
	to wash from fro						
	b. Cleanses from						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED	
		155670	B. WING			09/29/20	011
			D. WING		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				DSEBUD LANE		
KINDRE	O TRANSITIONAL C	CARE AND REHAB-ANGEL RIVER	1		IRGH, IN47630		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	\vdash	ID	PROVIDER'S PLAN OF CORRECTION	T	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	_	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
	The observation	was reviewed with the		ľ			
	Administrator an	d DoN on 9/27/11 at					
		oN indicated, during					
	•						
		yould have to review the					
	•	CNA #1, to always					
	cleanse front to b	back in the perineal area.					
	2.1.10/13/43						
	3.1-18(b)(1)						
F0514	The facility must m	naintain clinical records on					
SS=D		ccordance with accepted					
		ards and practices that are					
		ely documented; readily					
	accessible; and sy	stematically organized.					
	The clinical record	must contain sufficient					
		ntify the resident; a record of					
		essments; the plan of care					
	and services provi	ded; the results of any					
	preadmission scre	ening conducted by the					
	State; and progres						
		review and interview, the	F05	514	F 514		10/24/2011
	•	ensure residents receiving			AngelRiverHealth and		
	insulin were free	of significant medication			Rehabilitation		
	errors (Resident	#14), in that Resident			Plan of Correction		
	`	der for insulin at			Annual/Complaint Surv	ey	
		ot transcribed in a timely			r	1	
	· ·	in the resident not			Date: September, 2	_{21.}	
	_	ered insulin for 26 days,			2011	,	
	_	ats sampled for receiving					
		1			IndianaStateDept of		
	insulin in a facili	ty sample of 22.			Health		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

MQ3411 Facility ID: 011049

If continuation sheet Page 43 of 47

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	155670	A. BUI	LDING	00	09/29/2011
		133070	B. WIN			09/29/2011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
KINDRED TRANSITIONAL CARE AND REHAB-ANGEL RIVI		CARE AND REHAR-ANGEL RIVE	:R	1	OSEBUD LANE JRGH, IN47630	
(X4) ID				<u> </u>	1	(V5)
PREFIX				ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	Findings include	· •			Corrective action take	<u>n</u>
					for those residents for	<u>ınd</u>
	The clinical reco	rd of Resident #14 was			to have been affected	
	reviewed on 09/2	22/11 at 2:15 P.M. The			_	
	record indicated	the diagnoses included,			Resident # 14 was:	
	but were not limi	ited to, Diabetes Type II.			Assessed for adverse	
					reactions	
	_	Physician's Order Recap			Diabetic flow sheets w	
	included, but was not limited to, and order for : "Novolog sliding scale coverage QID				reviewed to assess for	
					accuracy in medication	
					administration and blo	ood
		g] -before meals and at hs			sugar levels	
	[hour of sleep]:				Medication Administra	
	< [less than] 70=	No coverage			Record was reviewed	for
	70-150=2 units				accuracy in	
	201-250=4 units				administration of medications	
	251-300=6 units 301-350=8 units				Medical record was	
	351-400=10 unit				reviewed for	
		s 400=10 units and call MD			documentation of the	
	[physician]	100-10 units and can MD			med error and	
	Use half dose at 1	hs "			appropriate follow up	at
		Physician's Order Recap			the time of the med en	
	_	a handwritten note signed				
	1 0	dated 08/04/11 which			Other residents having	,
	indicated, "Start Lantus 10 units at hs"				the potential to be	_
					affected by the same	
	The August 2011	Medication			practice:	
	_	Record [MAR] lacked any			_	
	documentation th	nat Lantus 10 units was to			Residents who have	
	be given at bedti	me.			Insulin orders are	
					identified by Medical	
	The Diabetic Mo	onitoring Flow Sheets for			Records Reports	

´		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155670	B. WING		09/29/2011
NAME OF I	PROVIDER OR SUPPLIER		l l	ADDRESS, CITY, STATE, ZIP CODE	
				OSEBUD LANE	
KINDREI	D TRANSITIONAL C	CARE AND REHAB-ANGEL RIVE	R NEWBU	JRGH, IN47630	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	~	icated Resident #14		All residents receiving	· I
	1 ^	ated blood sugars on the		Insulin will have clinic	al
		and received insulin per		records checked for:	
	the ordered slidir	•		Physician orders for	
	08/06/11 at 8:00			insulin	
	08/13/11 at 5:00	P.M. = 463		Accuracy in transcript	ion
	08/13/11 at 7:00	P.M.= "high"		of physician orders fo	r
	08/20/11 at 4:00	P.M.=432		insulin	
	08/27/11 at 8:00	P.M.=467		Accuracy in	
				administration of insu	lin
	A Physician's Tel	lephone Order dated		Accuracy in	
	08/06/11, no time	e, indicated, "give 15 u		documentation of insu	ılin
	[units] of Novolo	og now-recheck blood		administration	
	sugar in 2 hours-	Notify MD if blood sugar			
	>300."			Measures put into place	ce_
				and systemic changes	<u> </u>
	A Physician's Tel	lephone Order dated		made	_
	1 -	P.M. indicated, "Recheck			
		in 2 hoursGive total of		In - service education	will
	15 u Novolog no			be presented for all	
				licensed nurses regard	ding
	A Physician's Tel	lephone Order dated		the	<u> </u>
	l ř	P.M. indicated, "Give 20		Transcription of physic	cian
	u Novolog now			orders for insulin	
	u i ve veleg lie w	•		Administration and	
	A Physician's Tel	lephone Order dated		documentation of insu	ılin
	1 -	P.M. indicated, "Give 12			
		recheck in 2 hours-if over		Corrective actions will	l be
	400 notify MD a			monitored to ensure the	
		D*****		practice does not recu	
	A Unit 100 Foy o	dated 08/30/11 indicated,		by:	<u></u>
		w order] 08/04/11 Lantus		~) :	
	_	•		- The DNS, ADNS or	
	_	ic] resident did not		designee will do rando	,m
	receive this medi	ication all mo [month]"		uesignee will do rando	/'''

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DINC	00	COMPLE	ETED
		155670	B. WIN			09/29/20)11
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF	PROVIDER OR SUPPLIEF	₹					
KINDRED TRANSITIONAL CARE AND REHAB-ANGEL RIVER		D	1	OSEBUD LANE			
KINDKE	D TRANSITIONAL (CARE AND REHAB-ANGEL RIVE	ĸ	INEMAG	JRGH, IN47630		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					checks on those		
	A Medication Va	ariance Report Worksheet			residents who have		
		DoN [Director of			physician orders for		
	1 *	23/11 at 10:55 A.M.			Insulin (2) times per w	ook	
					• • •	I .	
	indicated, "Lanti				times six (6) months		
		nAdverse Drug			clinical records will be		
		Гуре of Effects observed			checked for accuracy i	in	
	or reportedOth	er" with a handwritten			the following:		
	note that indicate	ed, "increased blood sugar			Physician orders		
	resulting in incre	eased coverageType of			Diabetic flow sheets		
	_	sion" with a handwritten			Transcription of orders	,	
		ed, "Transcription			Administration of the		
		[received] 8-4-11 not			medication		
		. ,					
		edication Errors Severity			The Performance		
	_	Iarm Category E- An			Improvement Committ		
	error occurred th	nat may have contributed			will monitor findings o	I .	
	to or resulted in	temporary harm to the			random checks month	ly	
	resident and requ	uired intervention." A			times six (6) months		
	handwritten nota	ation in the right margin					
		t indicated, "[name of			Completion Date		
		e order on pink order sheet					
		[telephone order] Wrote it			October 24, 2011		
					October 24, 2011		
	on 3rd page inste	ead of fast."					
		ed 04/20/11 for Type II					
	Diabetes include	ed approaches which					
	included, but wa	s not limited to,					
		dications as ordered."					
	In an interview v	with the DoN on 09/23/11					
		ne indicated, "[name of					
	_	l not get the insulin					
		er was not transcribed to					
	the MAR."						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/29/2011	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-ANGEL RIVER			STREET 5233 F	ADDRESS, CITY, STATE, ZIP CODE ROSEBUD LANE BURGH, IN47630	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	COMPLETION
	3.1-50(a)(2)				